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Comprehensive primary health care under neo-liberalism in Australia

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ABSTRACT

This paper applies a critical analysis of the impact of neo-liberal driven management reform to examine changes in Australian primary health care (PHC) services over five years. The implementation of comprehensive approaches to primary health care (PHC) in seven services: five state-managed and two non-government organisations (NGOs) was tracked from 2009 to 2014. Two questions are addressed: 1) How did the ability of Australian PHC services to implement comprehensive PHC change over the period 2009–2014? 2) To what extent is the ability of the PHC services to implement comprehensive PHC shaped by neo-liberal health sector reform processes? The study reports on detailed tracking and observations of the changes and in-depth interviews with 63 health service managers and practitioners, and regional and central health executives. The documented changes were: in the state-managed services (although not the NGOs) less comprehensive service coverage and more focus on clinical services and integration with hospitals and much less development activity including community development, advocacy, intersectoral collaboration and attention to the social determinants. These changes were found to be associated with practices typical of neo-liberal health sector reform: considerable uncertainty, more directive managerial control, budget reductions and competitive tendering and an emphasis on outputs rather than health outcomes. We conclude that a focus on clinical service provision, while highly compatible with neo-liberal reforms, will not on its own produce the shifts in population disease patterns that would be required to reduce demand for health services and promote health. Comprehensive PHC is much better suited to that task.

1. Introduction

In 1978 the World Health Organisation (WHO) endorsed a visionary approach to Primary Health Care (PHC). The vision for PHC was comprehensive in that it related health services to the broader organisation of society, calling for a new international economic order that would benefit developing nations, empowering democratic participation in health, and greater attention to social and environmental contexts that increased disease risks. Health services were to be multi-disciplinary, attuned to local need, and emphasise disease prevention and health promotion. This vision was developed during a period of decolonisation in the global south and the rise of progressive social movements in the global north, both of which embodied optimism for a less exploitative future and challenged established power bases. Re-reading the Alma Ata Declaration one is struck by its essential idealism and also by its recognition that resistance to the changes was likely.

The resistance was indeed swift, with a call for a more 'selective' PHC approach published just one year later (Walsh and Warren, 1979). Wary of costs and political opposition to the Declaration's assertions, the article envisioned a 'selective' implementation as an 'interim' measure. Broader global transitions in political economy, however, made this temporary 'selective' approach a permanent feature.

1.1. Theoretical framework

The period immediately following the Alma Ata Declaration has

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been characterised in the political science literature as the rise and global dominance of a neo-liberal economic discourse and its subsequent shaping of public policy choices, which forms the basis of the theoretical framework that guided analysis of our study findings. Neo-liberal economic theory was developed in the 1940s and 1950s from a distrust of the potential of state-planned economies, which were perceived as autocratic and repressive of individual liberties (Hendrikse and Sidaway, 2010; Labonté, 2012). A principal axiom of neo-liberal economic theory is that economies are too complex for governments to manage, and that free markets, sovereign individuals, free trade, strong property rights and minimal government interference will yield the best outcomes (Hayek, 1944). When first propounded, this theory gained ground in some economic departments, notably at the University of Chicago, but was marginalized by a dominant post-war Keynesian economic model, Keynesian economics, which emphasised, in part, the importance of government interventions in market economies to support full employment, provide for social protection programs, use taxation to reduce market-based income inequalities and engage in counter-cyclical spending during economic downturns.

Neo-liberalism eventually gained prominence following the elections of conservative governments in the UK (Thatcher), USA (Reagan) and Germany (Kohl). These elections corresponded with declining profit margins and sluggish growth in 'advanced' economies, and coincided with oil price shocks and worsening developing country foreign debts, risking massive sovereign defaults and imposing painful structural adjustment programmes on indebted countries (Cornia et al., 1988). Although initially directed to facilitating the maximum freedom of movement for finance capital, goods and services in the commercial sector, neo-liberalism came to promote a market economy in public health care, education, and social security sectors. Neo-liberal policies were manifest in public spending cuts, privatised public services, and adoption of private sector modes of operation (Osborne and Gaebler, 1992). The opening of global markets through trade and investment liberalisation accelerated these processes, partly through reductions in marginal and corporate taxation rates as part of a (now) global competition to attract foreign direct investment. In parallel, there was widespread de-regulation (or re-regulation) of financial markets over the 1990s and early 2000s, which led to a series of regional financial crises that culminated in the 2008 global financial crisis. This crisis and its subsequent recession became the rationale for a more globalised 'austerity' response by most of the world's countries (Labonté & Stuckler, 2016). Thus, there has been a gradual global roll-out of neo-liberal economic policies which, although not dramatically affecting high-income countries such as Australia until roughly the period when our study began, has shifted fundamentally the political economy from when vision of a comprehensive PHC was first promulgated.

This global shift represented a headwind for WHO's PHC program, and since the early 1980s fuller implementation of the Alma Ata vision has been infrequent. Selective PHC, with its 'vertical' emphasis on treating or preventing certain high-burden diseases rather than a 'horizontal' effort to build public health systems, became more entrenched with health reform initiatives of the 1990s and 2000s that were consistent with the core elements of neo-liberalism: cost-containment and efficiency, result-based financing, user fees, managed competition amongst service providers, increased contracting out to private providers, and an emphasis on individual responsibility for maintaining good health.

There have been instances of more comprehensive PHC practices which have strived to fulfil the original Alma Ata vision and aimed to:

- increase equity in access to health care and other services essential to health
- promote community empowerment to reduce vulnerabilities
- address social and environmental health determinants
- improve community participation in health services and the political capabilities of marginalized groups and
- increase intersectoral policy actions on social and economic health determinants (Labonté et al., 2014).

In OECD countries, the best examples have been community health centres in Canada (http://www.cachc.ca/) the USA (Lefkowitz, 2007), and Australia (Baum, 2013). Despite different histories, these centres share: a multi-disciplinary practice, a social health vision, participatory management practices and comprehensive work embracing the Alma Ata continuum of rehabilitation, treatment, prevention and promotion. Often marginal within the health systems of their countries these centres sometimes faced powerful opposition from mainstream medicine and have rarely been the subject of systematic national programs. This study examined how neo-liberal policies affected the ability of Australian PHC services to implement a comprehensive vision of PHC.

1.2. Background to Australian comprehensive PHC study

The Whitlam Australian Government instituted a National Community Health Program in 1973. This program created one of the isolated examples of comprehensive PHC and resulted in many multi-disciplinary community health centres being established in every state and territory. Although the program was defunded after three years, two states – Victoria and South Australia - maintained program funding over the ensuing three decades. Australia also saw the development of comprehensive PHC in Aboriginal Community Controlled Health Services (Bartlett and Boffa, 2001; Wakerman et al., 2008). That these services have represented the best examples of comprehensive PHC in Australia made them the focus of our study to examine what makes for effective comprehensive PHC. An earlier international study (Labonte et al., 2008) found that most of the empirical PHC literature focused on "slices" or particular programs, and only rarely study the overall service in a systematic way. Our interest was to demonstrate the effectiveness of comprehensive PHC by studying the totality of the service in a way not previously reported in the literature (Labonté et al., 2014).

Over 5 years (2009–2014) we witnessed a steady imposition of health sector reforms which undermined the comprehensiveness of most of the services. These reforms reflected neo-liberal precepts emanating from a post global financial crisis austerity agenda that had rapidly globalised, even amongst countries that were not in any fiscally constrained situation, such as Australia. Hence our study created an unforeseen opportunity to study the impact of the imposition of these reforms on comprehensive PHC services.

The impact of neo-liberalism on public sectors in general and health sectors in particular have been extensively studied over the past three decades (Cornia et al., 2008; Mooney, 2012). Some of these impacts have been documented in Australia, such as the introduction of 'new public management' techniques derived from the private sector (Pusey, 2010). Despite variation in the implementation of these neo-liberal reforms across Australian jurisdictions (O'Donnell et al., 2011) there is a discernible movement in public sectors towards a market-oriented discourse of program and service management, a "hyper-rationality" (Germov, 2005) in which health care is seen as a commodity rather than a collective good or human right (Pellegrino, 1999). Payne and Leiter (2013) note that while health managers are able to exert some agency in opposition to this powerful new rationality, the new managerial logic is often at odds with professional and social values relating to

equity (Pellegrino, 1999). The parallel quest to reduce public sector expenditure in health services, however, has proved more difficult, and the continual growth in Australia's public health sector budgets has been a constant political concern (Baum & Dwyer, 2014). This policy environment, and the literature critiquing neo-liberalism, provides the background to a consideration of two questions:

1. How did the ability of Australian PHC services to implement comprehensive PHC change over the period 2009–2014?
2. To what extent is this ability shaped by neo-liberal health sector reform processes?

2. Methods

This study is a five year longitudinal case study design which drew on theory relating to comprehensive PHC and was designed as a realist evaluation which used program logic modelling to establish service qualities, output and outcomes (for details see Lawless et al., 2014). This paper draws on a synthesis of our findings and selected methods to examine our study findings in terms of critiques of neo-liberalism. PHC services in our case study.

The provision of PHC services is a complex mix of Federal and State involvement. The Federal government funds private fee-for-service General Practice through Medicare. Other PHC services are provided by the States and non-government organisations (NGOs), and differs between the states (Baum & Dwyer, 2014). Our study was conducted with seven PHC services between 2009 and 2014. The services were selected to maximise diversity, on the basis of willingness to commit to a 5 year project. The services are identified as follows: Congress - The Central Australian Aboriginal Congress Aboriginal Corporation, an Aboriginal community controlled organisation; SHine SA - a sexual health NGO; Services A, B, C, D (an Aboriginal health team), and E – the state-managed PHC services. Service B withdrew from further participation in the study in 2012, due to high staff workloads and significant organisational change. Service E agreed to join as a replacement. Further details of the services provided in Table 1. Each case study service adopted a reasonably comprehensive PHC approach at the onset of the study although A,C, E did not provide medical services. Both SHine SA (formed in 1969 as Family Planning South Australia) and Congress (formed in 1973) are non-government organisations governed by Boards of Management and founded as a result of public demand. In 2009 all services had organisational statements which demonstrated strong commitment to the Alma Ata Declaration principles including an explicit commitment to social determinants of health and health promotion.

2.1. Service audit data

Service data were collected from the services in a biannual audit which provided details of budgets, types of services offered, organisational documents and staff numbers.

2.2. Staff interviews

Our study interviewed staff in 2009 and 2013. The 2009 interviews and fuller details of the 2013 interviews have been reported elsewhere (Freeman et al., 2015). In 2013, 63 interviews were conducted with service practitioners and managers, and regional and central health executives. All the interviews were conducted by the study leaders and an Aboriginal research fellow.

Interview questions were developed by the research team based on the attributes of PHC and data collected on changes in PHC during 2009–2013, and piloted on two practitioners and one manager from non-participating PHC services. Interviewees were asked to rate out of 5 the comprehensiveness of the service currently and as it was in 2009. Interviews were audio recorded, transcribed, and de-identified. Ethics approval was received from the Southern Adelaide Clinical Human and Aboriginal Health Research Ethics Committees.

A team approach was taken to thematic analysis, aided by NVivo software. Codes were discussed and revised in team meetings, and four interviews were double-coded or triple-coded, ensuring rigour through constant monitoring of analysis and interpretation (Morse et al., 2002).

3. Findings

Earlier papers from this study provide detailed accounts of the data upon which this synthesis review of findings is based (Baum et al., 2014; Baum et al., 2012; Baum et al., 2013; Freeman et al., 2015; Freeman et al., 2011; Freeman et al., 2016; Freeman et al., 2014). In this paper we present findings related to the changes in comprehensiveness of service provision, before locating these in the neo-liberal health sector reforms that took place over the study period, and which contributed to the decline in comprehensiveness. These changes include centralised control, budget reduction and throughput measurement.

3.1. Less comprehensive service coverage

> … the whole energy of the place has gone, the vibrancy of a community based primary health care service is not there. It's not owned by the community. It's become this desolate sort of – the death star – it's slowly dying. (Practitioner Service A)

Over the five years centrally determined changes led to the five state-managed services becoming less comprehensive in their service provision.

The state-managed services experienced rapid, considerable and relentless change, (summarised in Table 1), from services that sought actively to engage with the community to focusing on managing chronic disease with individuals. Congress and SHine SA remained operating much as they had in 2009. This does not mean that they were unaffected, as discussed below, but the relative independence of these services afforded protection from the changes in a way that was not possible for the state-managed ones.

Fig. 1 contrasts how the respondents rated the comprehensiveness of their services on a five point scale at the time of the second interviews and as it was in 2009. All state-managed services experienced a significant drop in staff perceptions of comprehensiveness while Congress stayed steady and SHine SA declined only a little.

3.2. Change of policy direction towards selective PHC

A national health reform agenda had seen the Federal government establish regional PHC organisations – Medicare Locals – that, along with the State government's strong desire to control health care costs, resulted in the State government curtailing the scope of PHC to focus on chronic disease management, especially diabetes and cardiovascular disease, and vertical integration with the hospital system. One manager (Service E) noted: "So they basically said, 'Okay, all the primary health care belongs to Federal government now. We don't do that anymore.'" A SHine SA board member noted: "we are seeing a shift backwards from preventive care … the primary health, comprehensive health [policy of] 2003 … a real shift away from that." A practitioner at Service E

Table 1
Characteristics of case study PHC services: 2010 and 2013.

Service	Budget (p.a.)		Main source of funding	Governance	Approximate # of staff (FTE)		Range of services	
	2010	2013			2010	2013	2010	2013
A	$1.2 m	$0.5 m[a]	SA Health	State-managed	16 (13.5)	10 (8.1)	Early childhood, health promotion, community development, allied health, chronic condition self-management, mental health, lifestyle advisor	Early childhood
B	$1.1 m	$1.3 m[b]	SA Health	State-managed	26 (20)	28 (15.7) [b]	Medical clinic, allied health, early childhood, podiatry, chronic condition self-management, lifestyle advisor, health promotion programs and groups, community development, peer education	Medical clinic, allied health, early childhood, podiatry, chronic condition self-management
C	$1.7 m	$1.6 m	SA Health	State-managed	36 (22)	25 (15.3)	Chronic condition self-management, early childhood, family violence, mental health, supported residential facilities services, community garden, lifestyle advice, health promotion, local initiatives, parenting groups, mindfulness and meditation groups, healthy ageing	Chronic condition self-management, early childhood, family violence, mental health, supported residential facilities services
D	$0.5 m	N/A[c]	SA Health	State-managed	12 (10.8)	N/A[c]	Community lunch program, health promotion groups,1:1 case management/referral/ advocacy, transport, community events	Combined into medical clinic, Aboriginal clinical health workers, learning centre
E	N/A[d]	$1.7 m	SA Health	State-managed	N/A[d]	21 (16.6)	Early childhood, chronic disease self-management, mental health, antenatal and postnatal support, domestic violence services, healthy ageing, health promotion, community development[d]	Early childhood, chronic disease self-management, mental health, antenatal and postnatal support
Congress	$20 m	$20 m	Dept. of Health & Ageing	Aboriginal Community controlled board	320 (188)	310 (204.5)	Medical clinic, allied health, child health, chronic disease, women's health, male health, social and emotional wellbeing, pharmacy, dental, health promotion	Medical clinic, allied health, child health, chronic disease, women's health, male health, social and emotional wellbeing, pharmacy, dental, health promotion
Shine SA	$6.1	$5.8 m	SA Health + Dept. of Health & Ageing	Non-government with governing council	100 (55)	68 (50.7)	Sexual health capacity building for teachers, health professionals, sexual health school curriculum, sexual health clinic, counselling	Sexual health capacity building for teachers, health professionals, sexual health school curriculum, sexual health clinic, counselling

[a] Approximate – budget was combined with another site. Budget for 2 sites was $1.1 m.
[b] As of 2011, due to service withdrawing.
[c] Service was restructured and merged with another service, cannot calculate a comparison to 2010.
[d] Service joined study in 2012 – staff, budget info not available for 2010, services are as of 2012.

commented:

> The actual health reform and the actual orientation of the health service, has gone from very community based health promotion, illness prevention, to more subacute clinical services.

One SA Health Executive further explained:

> My brief is to align services to specific disease groups and really focus on an integrated model that targets the high users of acute services, because of potentially preventable readmissions as a result of chronic disease.

Closer links were being forged with hospitals, and specialist clinics were being run in the PHC services. Interviewees reported "they're calling it intermediate care rather than primary care" (manager, Service E), with the service "becoming more of an extension of the hospital setting than working at the earlier intervention" (practitioner Service C).

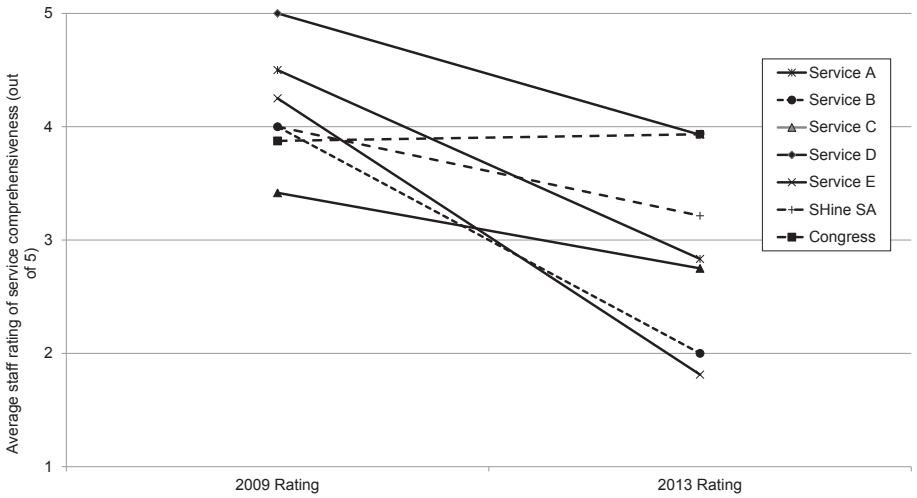

Fig. 1. Average staff rating of comprehensiveness of the service as it was in 2009 and at the time of the interviews in 2013.

3.3. Services lost

In 2009 the state-managed services offered a range of health promotion activity. Five years later this activity had almost completely ceased as a result of the government's response to a review of "non-hospital activity" (McCann, 2012). The Aboriginal service D reported that they were no longer able to deal with people with mental illness and had been directed to refer these clients to other agencies. Staff expressed concern that mainstream services often did not provide an adequate level of service and were sometimes culturally inappropriate.

The state-funded services had also been directed not to do domestic violence work, "which was incredible, because that underpinned such a lot of child development stuff" (practitioner Service A).

3.4. Strategies dropped

Over the five years we observed a withdrawal from strategies characteristic of a comprehensive approach: advocacy, an approach to service delivery grounded in an understanding of social determinants, community engagement and intersectoral action.

3.4.1. Advocacy

In 2009 each service reported at least a limited role in advocacy for the broader health of the community. By 2013 staff in the state-managed services reported that advocacy was not allowed; and, as a regional executive noted, "if there's [any] advocacy done it's more likely [to be] on a one-to-one basis in a clinical setting". Even so, staff reported that they had little scope to advocate about clients' social problems given their reduced ability to network and the focus on clinical services. At SHine SA, despite the service's ongoing commitment to advocacy, there was pressure because their funding agreement had become more restrictive:

> In the past the community health workers had non-clinic hours to work in sexual health advocacy and health advocacy for clients, but that's been eroded more and more. So now [with] a higher clinical load, there's less ability to do that. We're becoming less community health nurses and more just clinical practitioners. (practitioner, SHine SA)

3.4.2. Grounding in social determinants

Staff in the state-funded services reported few initiatives that allowed a social determinants approach grounded in the realities of people's lives. A regional executive noted "in the last couple of years those early policies of primary health and social determinants of health management have really just fallen away". A manager explained that "in the past we would have done more stuff on things like transport or unemployment or discrimination" and a practitioner that it was "getting harder to respond because a lot of the community development work I think was a better model for addressing social determinants".

Concern was also expressed that the new style did not take account of the impact social determinants had on people and made assumptions about the extent of people's agency to take action. This concern was particularly acute in the Aboriginal service, as one health worker explained: "there's always multiple issues with a lot of our clients and it's hard … you help with one and then there's another issue that pops up a few weeks later, so it's just continuous".

Practitioners stressed, and our audits of activities and earlier interviews indicated (Baum et al., 2012; Baum et al., 2013; Freeman et al., 2011; Freeman et al., 2014) that in 2009 the services provided support and therapeutic groups and events such as lunches which offered opportunities for social connection, information-giving, and informal support and allowed staff to understand the social and economic issues underlying people's health. A clear example of contrasting responses to social determinants was apparent in the Aboriginal services – there were severe cuts to transport assistance in Service D, whilst Congress expanded their transport service as they saw accessibility as vital to the effectiveness of the service.

3.4.3. Community development discouraged

In 2009 many staff did community work, utilising community development strategies and working with other sectors and community groups (Baum et al., 2012). By 2013 there were numerous accounts from practitioners of being directed that community development work was no longer permitted. Staff in one service reported being directed not to leave the building, "We're in our little insular box and we don't go out of that" (practitioner Service A). In 2009 this same worker had reported that she ran community groups and worked with a wide range of agencies and networks. She noted the difference by saying "that is the push, to sit here and be an expert telling people how they should live, and pushing them

out the door as quickly as possible."

3.4.4. Reduction in community participation

State-managed service staff noted a decline in opportunities for community participation. By 2013 all but one of the examples of substantive participation reported for 2009 (Freeman et al., 2016) had been stopped and the audit and interviews indicated no new instances had occurred. The increase in centralised control had meant less local planning and opportunities for community involvement:

> In the past we had a lot more local control over what we did based on our local knowledge and that was really respected and sought after in terms of we're working with the real people in the real space (practitioner, Service A)

In contrast, SHine SA and Congress had management boards (the state services had community boards until 2004) which protected comprehensiveness to some extent despite constraints imposed by funding agreements. A SHine SA board member explained:

> [Our] Board was able to negotiate to some extent what we were doing in the [funding] targets and … I don't think there's [been] a huge gap in terms of [being] comprehensive.

The existence of a community-controlled board gave Congress this freedom to implement a comprehensive strategy even in the face of Territory and Federal government neo-liberal strategies including tendering out of services.

3.4.5. Intersectoral collaboration. Many staff spoke of their previous engagement with other sectors including education, welfare, non-government agencies and local government. A practitioner described how the "Community Foodies" group which involved children centres and schools had been cut. At service E a manager noted that intersectoral collaboration has been "reduced a lot. So local government has been reduced, education has been reduced, well both of those are probably approximately zero". Practitioners at services E and C could no longer be involved in domestic violence prevention networks, "[I] just can't do it anymore, except in my own time" and "we were told no more committees, no more partnerships."

3.5. Impact of the loss of comprehensiveness

The perceived impact of service changes on clients and communities were frequently discussed. Many reported that the new strategy was short-sighted and likely to increase rather than reduce hospital admissions. Many staff noted the fracturing of long-established service networks. When a program is disbanded, "there goes all of that hard work and the years of history of collaboration" (practitioner, Service E).

Many practitioners reported they were less able to work effectively with people facing multiple disadvantage in their lives. This perspective was well explained by a practitioner at Service D in describing the impact of the loss of the groups:

> Mums and bubs, the women's groups, the men's groups and the youth group, all of them. We no longer can talk the talk to them about health promotion because we don't have these groups anymore … …some are reverting back to their old lifestyles because they have nothing anymore during the week to do. Especially if you're unemployed or never been educated. It's daunting to know that there's nothing anymore left for them. They feel just sad.

Similarly a practitioner at Service A explained that the individual focus and absence of groups and community development strategies might work well for "people who are really high functioning and haven't got all these issues going on in their life" but that "for the people that we're most trying to access, the most disadvantaged people with the most chaos going on, that kind of stuff doesn't work".

A practitioner at Service C noted the importance of integrated services for people facing multiple disadvantage and with limited ability to manage their own health care: "Even just getting those people in for an appointment, never mind getting them to see five different people at different physical locations or different times … having one place that they can come to [was] a really important thing." Staff feared this integration was being lost as services focused on particular diseases and tightened access criteria. These changes were perceived by staff as signalling a change in values. As a practitioner at Service A said "this social justice stuff, it's so important to us, that's just dying".

3.6. Neo-liberal management practices

Alongside changes in service provision, management strategies which reflected the neo-liberal practices discussed in the background to this paper had profound impacts on the state-managed services as described below.

3.6.1. Uncertainty

Staff reported significant flux, turnover of management staff, a rapid pace of change and uncertainty about the future of their service. Changed management practices included short-term staffing contracts (3 months in some cases) and late renewal of contracts, with permanent contracts becoming "a thing of the past" (practitioner, Service C). All state-managed services reported a high turnover of staff. In one region there had been four directors of PHC services in two years. Changes were not well-communicated and many staff reported being "bemused", "confused" with "a lot of uncertainty about where we sit in the wider health care system". One practitioner in Service D summed this up "It seems like every six months we're changing our titles or we're changing the lettering or the abbreviation of our service, and if we accidentally say the wrong thing you get your head bitten off". Another complained that "it just seems so erratic and sudden and un-thought out" (practitioner, Service A).

Managers also reflected on uncertainty. One regional executive noted "I don't sense a really positive environment here, I think it's confused and I think it's just idling". Another said "to be honest, it's not clear at this point what will continue to be funded beyond the end of the financial year".

As a result of almost chronic uncertainty, morale had been "quite poor over the last couple of years because people aren't quite sure what the direction is of primary health care" (practitioner, Service B). A few staff had a sense that "there is more of that [change] to come" and that "it is going to get worse".

While there had been significant change, including a new CEO, at the two NGOs the sense of uncertainty reported was much less than at the state services and primarily concerned changes to funding that was becoming increasingly tied, competitively tendered and short term. While these funding changes may have made it more fiscally and administratively difficult for the organisations to retain comprehensiveness, they retained the autonomy to define the scope and practice of their work because management

control remained local.

3.6.2. More central managerial control

The degree of control exerted by the PHC services reduced over time for all services except Congress. SHine SA had restrictions placed on the service by its service agreement with SA Health, its main funder. Staff in state-managed services spoke of "rigid rules" and "edicts coming from on high" and of "losing a lot of that autonomy, that we can't really influence what that direction might be." (Practitioner Service B). The language used was very much "they" are doing this to us. A manager at service C expressed: "We're very, very managed about what we do and what we don't do".

There was also evidence of careful 'packaging' of changes, camouflaging the actual cuts taking place. An example was that cuts to health promotion services were described as "transitioning" because the health sector hoped to outsource the function to local government or an NGO:

> Transition is the word. No program is finishing, it's transitioning. And some staff have been told off about that. They've told community members that a program's not running anymore, and they've been quickly told, "It's not, that's incorrect, it's transitioning, and other people are better placed to run services than us" (practitioner, Service C).

Although not immune to the policy and funding changes, neither Congress nor SHine SA staff reported the degree of loss of control experienced in the other services. SHine SA felt pressure from SA Health in their service agreement negotiations to be less comprehensive in their approach and as one Board member put it "we're now being told how we're going to work and who we'll provide services to". Congress reported similar pressures from their funders with one manager noting that if their programs were not designed in line with "what the government wants" that "you don't get funded", perhaps foreshadowing that this increased control might affected comprehensiveness of the NGOs in the future.

3.6.3. Budget reduction and competitive tendering

The backdrop of this study was a constrained State budget and political determination to contain the health budget. The service audits indicated budget cuts at all the South Australian services (see Table 1). This budget pressure was a recurring theme in the state service interviews. A regional executive commented that the building of a new hospital had put increased pressure on the budget, " [the hospitals] just ask for more money and somebody squawks and somebody goes to the media". Even small budget items, such as toys for the early childhood team were being squeezed: "Funding-wise, everything's just scrutinised, completely and utterly scrutinised" (practitioner Service C).

Congress did not see its budget reduced but did report that Federal government funding was increasingly tied to competitive tendering processes. These threatened continuity of service provision and potentially opened PHC to private providers. The tendering also created uncertainty:

> So while our funding has been stable up until now, well, we've had to reapply for funding at certain times, we're coming up to a point of uncertainty now, having about ten months left before we either disband [our service] or continue and that's been a huge problem for our team (practitioner, Congress).

The budget pressures were also leading to some privatisation. At Service E, work was being referred to private clinical providers who rented space in their facility. The manager reported "the area that's increased … is the private sector. So the Super Clinic particularly has an explicit need to engage private providers".

3.6.4. Focus on short-term measurable throughputs

Another factor underpinning the service changes we observed was the imperative for the health system to measure short-term throughputs rather than longer term social and health development goals. A practitioner at Service E explained: "It's about throughput … that's where we're heading. … it's about activity-based funding, it's about numbers". Another at Service C said of the local people, "they've now come back to being a number, really, they've come back to being objectified. They're a stat."

The focus on throughput, alongside budget constraints, put pressure on community development programs to demonstrate their worth. Thus one manager (Service C) noted that community development was not seen to demonstrate large-scale sustained health changes:

> So you can see on some level, people would say, with a finite budget, and we're not getting sustainable long-term, meaningful outcomes for people, that maybe that wouldn't be the thing that we would invest our dollar in.

Such an assessment, however, leaves unexamined why funding is limited, or where it could or should be applied to greater effect. It suggests a hyper-rationality (typical of neo-liberal reforms) which reduces measurement to specific, quantifiable outputs that fail to capture some of the essential, social and relational dimensions of peoples' well-being. This emphasis on easily quantifiable outputs also constrained collaboration:

> Everybody's getting pushed more on their own KPIs (Key Performance Indicators) and actually nobody has KPIs around collaboration. … you concentrate on the things that you're going to be accountable for and not on the other things that you know is good. (manager, Service C)

Along with a desire to measure throughput came the much tighter management style described earlier which had become almost Fordist in its orientation:

> … people have regular emails saying 'I notice you don't have many clients booked, why not?' That's because they can see your diary electronically. And so there is a lot more emphasis on impersonal performance checking, and a much more rigid kind of approach to the way the work is done (practitioner, Service E)

One Congress manager commented on the limits of this approach: "I think government funds bums on seats, episodes of care. I could tell you I have done 20 episodes of care for the day, but what have I done?" A practitioner at Service E noted that previously her service had a sophisticated system of assessing program proposals and quality assurance processes which were "much more interactive and personal". In the new system "you don't see people, they just check you electronically really". Another at the same service said it was like "just being a little widget doing a widget job, which is what you end up feeling if you're just churning people through like a factory worker, like people are widgets and we are putting them through," where it is about "counting numbers of patients rather than quality [of services]". A regional executive agreed that the system was tightening considerably and noted "it takes a long time to see outcomes and Treasury needs to see something right now". This need for a shorter time scale did not

favour comprehensiveness as a SHine SA Board member noted:

> I think comprehensive approaches are easier to cut simply because they work on a longer timeframe, the cause and effect relationship is less easy to define, and I think in an environment where people are being asked to be more accountable you fund what you can count.

One service CEO levelled part of the blame on PHC's lack of attention to measurement in the past, "that community health has lost that opportunity, it's been driven a lot by qualitative work and not enough by health economics and quantitative measurements" leaving comprehensive PHC services vulnerable to being cut. A regional executive in talking about the community development and health promotion programs was blunter: "I'm looking at it from a pragmatist that's never really seen any discernible outcomes of those services". This sentiment was institutionalised in a state-government review (McCann, 2012) that led to the defunding of most health promotion programs, asserting that there was no evidence for the effectiveness of health promotion programs. This led some services' staff to regret that more evidence had not been available, while others noted that producing direct causal evidence of impact was not easy in developmental programs.

4. Discussion

> I think it's going to get less comprehensive unless the taxes get right up, which I would be all for. Bang up all the taxes really high and let's have a really good health system. (manager, Service C)

Fig. 2 summarises the main elements of neo-liberalism and how these are evident in the changes we have observed and had reported to us over the 5 years of this study. The convergence of neo-liberalism and these changes became evident through our thematic analysis. We were struck by how the reforms in South Australia have mirrored those noted in the literature (Germov, 2005; Global Health Watch, 2014; Labonté, 2012; Miller and Orchard, 2014; Oritz and Cummins, 2013) and were particularly marked by a quest to reduce public deficits, control public spending on health services including by reducing public sector employment and increasing the focus on easily measurable throughputs.

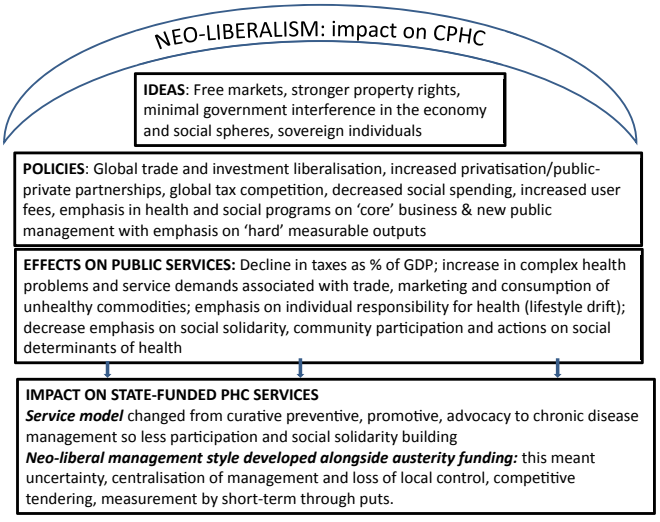

Fig. 2. Neo-liberalism and its impact on comprehensive primary health care.

Shortly after our study began federal and state policy reforms combined with the global financial crisis to create fiscal restraints. Subsequent health system restructuring affected the ability of most services to retain their comprehensiveness (Baum & Dwyer, 2014). The non-government services were more able to maintain comprehensiveness. In the state-managed services we observed a shift from a more comprehensive to an almost entirely selective PHC. The changes are likely to have improved vertical integration between hospitals and the PHC services for selected diseases but have drastically undermined the scope for horizontal integration which is recognised as vital to an effective PHC system (Thomas et al., 2008). Congress was most comprehensive at the outset and has been the most successful in maintaining its comprehensiveness, but even in this case neo-liberal pressures were evident.

4.1. New public management and cost cutting

Davis' (1995, pp. 132–3) description of neo-liberalism bringing a new style of public sector management characterised by "machismo management style that cuts, burns and slashes while demanding commitment to the new corporate culture and a health care market that is governed by a logic of cost rather than care and compassion" has clear resonance with our study. Staff described the ways in which the management had become focussed on cost-cutting and narrowing the service mandate. High levels of uncertainty and lack of effective communication about the change indicated a chaotic management in which the thoughtful planning required for a comprehensive approach was absent.

The recasting of the role of PHC from a comprehensive mandate to primarily providing services for people with physical chronic disease in order to reduce hospital demand was driven by the political desire to reduce public expenditure. Any broader mandate was seen as unaffordable in keeping with the neo-liberal quest to reduce the size of public services (David, 2014). In Australia, Pusey (2010, p. 135) work has shown that the ascendancy of neo-liberalism has meant the public service ethos has been focused on economic efficiency at "the expense of other substantive long- and mid-term goals" which has come "at great cost to our collective intelligence, to the historical creative, nation-building role of the Australian state". Certainly the focus on short-term easily measureable goals rather than on longer term investment in community building and social justice we found in the state-managed service supports Pusey's arguments. PHC services were reduced to a residual, selective set of services and the visionary element of the Alma Ata Declaration and the Whitlam Community Health Program were lost.

4.2. What's valued and measured

The new public management (Germov, 2005) favoured by neo-liberalism puts great emphasis on measuring the immediate output of expenditure. In our study the direct clinical work with clients was valued because its outcomes were more immediate, measureable and accountable. By contrast the community development work was seen as unaccountable because the outcomes were hard to quantify, long term and diffuse. Longer term developmental activities that engaged with communities to build trust and involvement were cut, having an effect that is reminiscent of Coburn's (2000) description of how neo-liberal policies reduce the ability of public services to build social cohesion.

The focus on measuring individual throughput reflects the individualism that is a hallmark of neo-liberalism (Harvey, 2005). The measurement of population impact was not reported as being of concern in the PHC reforms. Rose's (1992) work demonstrates that shifts in population health status cannot result primarily from

attention to individuals at high risk of disease but will mainly result from strategies that address the operation of risk factors across the entire population so that the number of people developing a disease is reduced. We found no recognition of this in the pattern of reform. Comprehensive PHC work should be judged in terms of its contribution to reducing risk across a whole population. The staff who had engaged in community development were aware of this and stressed how a focus on broader social factors could lead to better health outcomes (and so fewer expensive hospital services). But many others accepted the rhetoric that one advantage of the shift to clinical services is that they were measurable.

Congress is better placed to measure what impact their service has because they have an enrolled population and can take a whole of population view.

4.3. Strengths and limitations

A major strength is that we followed services over 5 years and were able to document in detail the ways in which their internal structure and operating environment changed. There are no other reports of such a study in the literature. We were also able to compare the service that changed least (Congress) with those that changed more and this comparison enabled us to derive lessons for comprehensive PHC and its operation.

The study was based on 6 services one of which withdrew from the study mid-way through (and was replaced with another). While this enabled us to collect very detailed data we also acknowledge that the number is small.

5. Conclusion

This study has shown the ways in which neo-liberal reforms have adversely affected the comprehensiveness of primary health care services. The state-managed services' mandate had been changed from a health promoting and disease prevention community-engaged model to one which was more akin to a hospital outreach service for those with existing chronic disease. We have highlighted those features of neo-liberalism which encouraged and supported this narrowing of the PHC service mandate to a selective approach. This approach bears little resemblance to the ways in which the WHO (1978) Declaration of Alma Ata envisioned primary health care as a vital part of a broader mandate of economic and social development in which governments assumed responsibility for promoting the health of populations to maximise health and well-being. A focus on clinical service provision, while highly compatible with neo-liberal reforms, will not on its own produce the shifts in population disease patterns that would be required to reduce demand for health services and promote health. Comprehensive PHC is much better suited to that task.

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